STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	A. BUILDING 00 COMPI	
		155198	B. WING		02/27/2012
				ADDRESS, CITY, STATE, ZIP CODE	L
NAME OF P	PROVIDER OR SUPPLIE	R		OWNSHIP LINE RD	
MARQUE	TTF			IAPOLIS, IN 46260	
				17.11 02.10; 114 102.00	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for a Recertification and State Licensure Survey.		F0000	The creation and submission	
				this plan of correction does no	
				constitute as an admission of conclusion set forth in the	any
	Survey dates:	February 20, 21, 22,		statement of deficiencies or a	nv
	23, 24, and 27	•		violation of regulation(s).	',
]	
	Facility number	er: 000105			
	Provider numb				
	AIM number:				
	Alivi number.	n/a			
	Survey team:				
	Connie Landm				
	Diana Zgonc F	RN			
	Lora Brettnach	ner RN (February 20,			
	21, & 22, 2012	2)			
		•			
	Census bed ty	vpe:			
	SNF:	86			
	Residential:	61			
	Total:	147			
	TOlai.	147			
	0	Access to			
	Census payor				
	Medicare:	21			
	Other:	126			
	Total:	147			
	Stage 2 Samp	le: 29			
	Residential Sa				
		•			
	These deficier	ncies also reflect state			
		n accordance with 410			
	IAC 16.2.	accordance with a re			
	17.0 10.2.				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE.	TITLE	(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 02/2	E SURVEY PLETED 7/2012		
MARQU			STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
		3/01/12 by Suzanne						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT11

Facility ID: 000105

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155198	B. WING		02/27/2012
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
MARQUE	ETTE			OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0164 SS=D	483.10(e), 483. PERSONAL PROFESONAL PROFESONAL PROFESONAL PROFESONAL PROFESONAL PROFESONAL PROFESONAL PERSONAL PROFESONAL PROFESON	75(I)(4) RIVACY/CONFIDENTIALITY Is the right to personal privacy lity of his or her personal and by includes accommodations, ent, written and telephone s, personal care, visits, and hily and resident groups, but quire the facility to provide a			
	health care instirequired by law The facility mus information con records, regard methods, exceptransfer to another	ent is transferred to another itution; or record release is et keep confidential all tained in the resident's less of the form or storage of when release is required by her healthcare institution; law; nent contract; or the resident.			
	Based on obse and interview, ensure privacy information by Administration uncovered for reviewed for p	ervation, record review the facility failed to of a resident's medical leaving the Medication Record open and 1 of 29 residents rivacy in a Stage 2 (Resident #186).	F0164	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: While the nurse involved in the alleged incident did not follow best practices, the cart was always within line of site. The nurse observed the surveyor approach the cart and therefore	e

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Event ID: S5QT11

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 ${\small \ \ \, If continuation \ sheet } \qquad \hbox{Page 3 of 30} \\$

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155198	B. WIN			02/27/2	2012
			Б. W II V	_	ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
MARQUE	TTE				IAPOLIS, IN 46260		
MANQUI	_ _			INDIAN			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings includ	le:			the resident's information was	I	
					never truly at risk. The medica		
	During observa	ation of the medication			administration record for resid		
	_	floor Rehabilitation			#186 was immediately protect	ed	
					by the nurse involved in the		
		2 at 9:40 A.M., the cart			alleged incident.		
	was unattended and the Medication				How other residents having t	ho	
	Administration	Record (MAR) was			potential to be affected by th	I	
	open to Reside	ent # 186's			same deficient practice will be		
	medications.				identified and what correctiv		
					action(s) will be taken:	`	
	During an interview with LPN # 1 on 2/27/12 at 9:45 A.M., she indicated				All residents have the potentia	l to	
					be affected by the alleged		
		,			deficient practice. All licensed		
		nsible for the rehab			nurses and qualified medication		
		t. She also indicated			aides (QMAs) will be re-educa	ted	
		e should not have left			regarding the residents' rights	to	
	the book open	or the medications on			personal privacy and		
	top of the cart	unattended.			confidentiality of his or her		
					personal and clinical records.		
	A current facilit	ty policy dated 1/1/05			NA/lead management will be must imper	.	
		eral Guidelines for			What measures will be put in	το	
		Medication" and			place or what systemic		
	1				changes will be made to ensure that the deficient		
	1 .	e Director of Nursing on			practice does not recur:		
		30 P.M. indicated,			The nurse involved in the alleg	her	
	" Standards o	of Practice for			incident has been reprimanded		
	medication adr	ministration:			accordance with facility policy		
	6. Maintain	privacy of medical			re-educated regarding the		
	records."				residents' rights to personal		
					privacy and confidentiality of h	is	
	3.1-3(o)				or her personal and clinical		
	0.1-0(0 <i>)</i> 				records. All licensed nurses a	nd	
					qualified medication aides		
					(QMAs) will be re-educated	.	
					regarding the residents' rights	to	
					personal privacy and		
					confidentiality of his or her personal and clinical records.		
					Continuing education will occu	ır	
			ı		I continuing contration will occu		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155198	B. WING		02/27/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	R		OWNSHIP LINE RD		
MARQUE	TTE			IAPOLIS, IN 46260		
				1711 OE10, 114 40200		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION)	TAG		DATE	
				with newly hired nurses and		
				qualified medication aides	or	
				(QMAs) and annually thereafter for all nurses and qualified		
				medication aides (QMAs).		
				modication aldes (Qivii to):		
				How the corrective action(s)		
				will be monitored to ensure t		
				deficient practice will not red	cur,	
				i.e., what quality assurance		
				program will be put into place	e:	
				Nursing administration will		
				complete random audits daily		
				through March 31, 2012,		
				randomly three times a week through April 30, 2012, and th	on	
				weekly through May 31, 2012		
				Information gathered from the		
				audits will be forwarded to the		
				committee quarterly. See	α, ι	
				Attachment A, Medication		
				Administration Audit Form.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		155198	B. WING		02/27/2012	
NAME OF P	ROVIDER OR SUPPLIER		8140	TADDRESS, CITY, STATE, ZIP CODE FOWNSHIP LINE RD NAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0272 SS=D	The facility must periodically a constandardized repeach resident's fixed assessment of a RAI specified by must include at led lidentification and Customary routing Cognitive pattern Communication; Vision; Mood and behave Physical function Continence; Disease diagnos Dental and nutrity Skin conditions; Activity pursuit; Medications; Special treatment Discharge potentic Documentation or regarding the additional regarding the r	VE ASSESSMENTS conduct initially and mprehensive, accurate, producible assessment of unctional capacity. ake a comprehensive resident's needs, using the the State. The assessment east the following: d demographic information; ne; ns; irior patterns; Il-being; ning and structural problems; is and health conditions; ional status;				
	Documentation of assessment.	οι μαιτισιματιστί ΙΤΙ				
	and interview, t ensure accurate done for 1 of 13	rvation, record review the facility failed to e assessments were residents reviewed is in a Stage 2 sample #104).	F0272	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: As documented in this survey, Resident #104 demonstrated to ability "to fully open her hands and fingers". She was screened	he	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, pull poug 00		00	COMPLETED	
		155198	A. BUILDI	ING		02/27/	2012
			B. WING	TENEET A	DDDEGG GITY GTATE ZID GODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
MADOLII					OWNSHIP LINE RD		
MARQUETTE			INDIAN	APOLIS, IN 46260			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PR	EFIX			COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)		DATE
	Findings include	le:			on 2/28/12 by hospice		
					occupational therapy, which		
	Resident #104	's record was reviewed			provided this assessment:		
	on 2/23/12 at 9				"During the evaluation, the	_	
	011 2/23/12 81 3	7.40 A.W.			resident actively opened hand		
					with verbal cues. Therapist was able to gently range digits. The		
	_	ses included, but were			was no increased tone	ICI C	
	not limited to, h	•			observed." The therapist		
	carcinoma - me	etastatic, SDAT (senile			recommended bilateral soft pa	alm	
	dementia - Alz	heimer's type),			protectors and alternate use s		
	constipation, agitation/delirium,				patient is able to use right han		
	hepatic encephalopathy, Alzheimer's				functionally for ADLs. Soft pa	lm	
		lepressive disorder.			protectors were ordered, per		
	Discase, and e	repressive disorder.			hospice.		
	During the staff	finterious on 2/22/12			How other residents having		
	_	f interviews on 2/22/12			the potential to be affected b	-	
	-	LPN #2 indicated			the same deficient practice v	vill	
		had contractures of			be identified and what		
	both hands and	d received daily ROM			corrective action(s) will be		
	(range of motion	on) exercises.			taken:	ıl to	
					All residents have the potentia be affected by the alleged	וו נט	
	The Quarterly	MDS (Minimum Data			deficient practice. A facility-wi	ide	
		ent, dated 1/19/12,			audit was completed to identif		
	· ·	r and lower extremity			residents with limited range of	-	
		<u> </u>			motion and to ensure appropri		
	,	s, wrists, hands, legs,			interventions are in place to		
		et) ROM had no			increase range of motion and/	or	
	impairment.				prevent a decline in range of		
					motion. Any residents		
	The Quarterly	MDS Assessment,			demonstrating a decline or		
	dated 10/25/11	, indicated upper and			change in functional capacity	.+	
		ROM- no impairment.			were assessed for a significan change of condition and a	IL	
		,			comprehensive assessment w	<i>i</i> as	
	The Significant	Change MDS			completed as indicated.		
	_	_			What measures will be put in	nto	
	•	ated 8/9/11, indicated			place or what systemic		
		er extremity ROM had			changes will be made to		
	no impairment.				ensure that the deficient		
					practice does not recur:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155198				02/27/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
MADOLI					OWNSHIP LINE RD		
MARQUE	=11E			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The current ca	re plans available in			All residents will be assessed		
	the record were all originated on				range of motion upon admission		
		re plans were printed			quarterly, and with any signific		
		ich was the last care			change of condition. Resident		
		te also. The current			identified with significant chang will be discussed in the daily	ges	
	l -				interdisciplinary team meeting	to	
	care plans did				ensure interventions are in pla		
		splint or Range of			How the corrective action(s)		
	Motion.				will be monitored to ensure t	he	
					deficient practice will not rec		
	During an interview with the Second				i.e., what quality assurance	·	
	Floor Unit Manager (UM) on 2/23/12				program will be put into plac	e:	
	at 10:45 A.M	she indicated the			All residents will be assessed		
	· · · · · · · · · · · · · · · · · · ·	ve contractures of both			range of motion upon admission		
	hands.				quarterly, and with any signific	ant	
	nanas.				change of condition. Nursing		
	Di.a. a la a a a a a	tion of Docidons #404			administration will conduct aud		
	_	ation of Resident #104			to ensure appropriate reporting and referral for treatment has	3	
		0:50 A.M., Resident			been completed for those		
	#104 was instr	ucted by the UM to			residents in their assessment		
	open her hand	s and fingers, which			review period. Any residents		
	were in a close	ed position. The			exhibiting a decline in function	al	
	resident was a	ble to fully open her			capacity will be referred to		
		ers, but needed some			therapy for screening.		
		ner right hand to open			Information gathered from the		
		The UM indicated the			audits will be forwarded to the	QA	
					committee quarterly. See		
		thritis in her hands,			Attachment B, Comprehensive)	
	_	larged knuckles, stiff			Assessment Audit Form.		
	joints and croo	ked fingers.					
	At this time, the	e UM indicated the					
	resident should	be evaluated for					
		possible splinting to					
		ctures and the risk for					
	l ·	nould be addressed on					
	the resident's of	care pian.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE COL	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
	155198	A. BUILDING B. WING		02/27/2012	
NAME OF I	PROVIDER OR SUPPLIER	8140 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
	A current facility policy, dated 4/07 and last reviewed 2/12, titled "Rehabilitative Nursing Care", provided by the DON (Director of Nursing) on 2/27/12 at 8:30 A.M., indicated: " Policy Statement: The facility will provide nursing care in order to (1) meet ADL (Activities of Daily Living) needs for those residents unable to carry out these activities; (2) prevent decline in positioning, ADLs or ROM; or (3) maintain or improve positioning, ADLs or ROM abilities Procedure: General rehabilitative nursing care is that which does not require the use of a Qualified Professional Therapist to render such care. 1. The goal of the facility's rehabilitative nursing care is designed to assist each resident to achieve and maintain an optimal level of self-care and independence through normal activities of daily living 4. Through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc." 3.1-31(c)(3)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	NING	00	COMPL	ETED
		155198	B. WING			02/27/	2012
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OWNSHIP LINE RD		
MARQUE	TTE				APOLIS, IN 46260		
WARQUE	.			אואטואוו	AI OLIS, IIV 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	PLANS	0(k)(1) PREHENSIVE CARE se the results of the					
	assessment to de	evelop, review and revise the ehensive plan of care.					
	resident's compr	erierisive piari of care.					
	care plan for eac measurable obje meet a resident's mental and psyci	develop a comprehensive ch resident that includes octives and timetables to see medical, nursing, and hosocial needs that are comprehensive assessment.					
	are to be furnished resident's highest mental, and psyconequired under § that would otherw §483.25 but are resident's exercise	ust describe the services that ed to attain or maintain the st practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under					
	Based on obse	rvation, record review,	F027	9	What corrective action(s) will		03/28/2012
	and interview, t	he facility failed to			be accomplished for those		
	ensure care pla	ans were developed for			residents found to have been	l	
	all areas of care	e needed, for 1 of 13			affected by the deficient practice:		
	residents review	wed for care plans in a			Resident #68 was not adverse	lv	
		e of 29 (Resident #68).			affected by this alleged deficie	•	
	Findings includ	e:			practice. The resident's comprehensive care plan was reviewed and updated to reflect current interventions for		
		record was reviewed			restorative nursing and splint		
	on 2/24/12 at 1	:05 P.M.			usage. How other residents having t	he	
	not limited to, s	ses included, but were epsis, UTI (urinary hypothyroidism, ARF			potential to be affected by the same deficient practice will b identified and what corrective action(s) will be taken:	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00 CO			ETED
		155198				02/27/	2012
			B. WING	_	DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					OWNSHIP LINE RD		
MARQUE	EIIE			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	(acute renal fai	ilure), paraplegia with			All residents have the potentia	al to	
	spasticity, urina				be affected by this alleged		
	depression, personality disorder, IBS				deficient practice. Residents		
		syndrome), OA			requiring restorative nursing a		
		,			or splints were identified durin	-	
	(osteoarthritis),				facility-wide audit and their car		
	(gastroesophageal reflux disease), and neurogenic bladder.				plans were modified as indicate	iea.	
					What measures will be put in	nto	
					place or what systemic	110	
	During an interview with the first floor				changes will be made to		
	Unit Manager (UM) on 2/23/12 at				ensure that the deficient		
	10:15 A.M., she indicated Resident				practice does not recur: Care	<u> </u>	
	#68 had contractures of her hands,				plans for residents receiving		
		·			restorative services will be		
		exercises, and did not			reviewed and updated per the		
	have splints.				MDS schedule and as needed	l.	
					Nursing administration and		
	During intervier	w and observation of			restorative staff will meet mon	thly	
	Resident #68 c	on 2/21/12 at 1:30 P.M.,			to review and revise individual		
		as not observed with			progress and plans of care. H		
	splints in place				the corrective action(s) will b	e	
		•			monitored to ensure the		
	Danie a aleman	45			deficient practice will not rec	eur,	
	_	ation and interview with			i.e., what quality assurance		
		2/24/12 at 10:00 A.M.,			program will be put into place		
	the resident did	d not have splints in			Nursing administration will aud		
	place. During	the interview, the			care plans for residents requir	ing	
	resident indica	ted she had splints, but			restorative nursing and/ or splints. The audits will occur		
		them at night. The			weekly for 4 weeks and month	nlv	
	_	esent in her wall			thereafter. Information gather	-	
	cabinet.	Cochi in fici wall			from the audits will be forward		
	Cabillet.				to the QA committee quarterly		
					See Attachment C, Care Plan		
		w with the UM on			Audit Form.		
	2/24/12 at 10:1	5 A.M., she indicated					
	she did not bel	ieve the resident had					
	splints.						
	1						
	The Occupation	nal Therapy discharge					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	I DING	00	COMPL	ETED
		155198	B. WIN	02/			2012
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			OWNSHIP LINE RD		
MARQUE	ETTE				APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	note, dated 12	/7/11, indicated an					
	"appropriate hand/wrist splint for " bilateral upper extremities was "on order."						
	order.						
	A current physician's order, dated						
	1	ated "passive ROM					
	•	ower extremities) twice					
	1	er, dated 12/4/11,					
		sive ROM to BLE twice					
	daily". Another order, dated						
	12/30/11. indic	ated "PROM to BLE					
	twice daily". T	here was no					
	physician's ord	ler for the use of a					
	l · •	ses to the resident's					
	hands.						
	Tidiras.						
	The current ca	re nlan, dated					
		essed the intervention					
	· ·	sive ROM) bid (twice a					
		, ,					
	1 • '	problem of requires					
		n completing ADLs due					
	to impaired mo	Dility.					
		vas documented to be					
		e Program for her					
	bilateral lower	extremity exercises.					
	Notes indicated	d the resident was					
	cooperative with	th the exercise					
	program.						
	The current ca	re plan lacked					
	documentation	•					
		or a Restorative					
		o a Nesionalive					
	Program.						

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Event ID: S5QT11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155198			TIPLE COI	NSTRUCTION 00	(X3) DATE (COMPL 02/27 /	ETED
NAME OF I	PROVIDER OR SUPPLIE	R		8140 TC	DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SECY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	The current ca 12/21/11) and address or me During an inter UM, on 2/24/12 indicated thera resident had resident just no splints. The resplints came was previous facility on herself even A current facility and last review "Rehabilitative provided by the Nursing) on 2/2 indicated: " Policy State provide nursing meet ADL (Act needs for those carry out these decline in positions."	re plan (dated Nurses Notes did not ntion splints. Eview with the first floor 2 at 3:05 P.M., she up had indicated efused their splints. The she had spoken with ow concerning the esident indicated the with her from her y, and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy, dated 4/07 and she puts them ry night. Ety policy at extending the puts them ry night. Ety policy at extending the puts them ry night. Ety policy at extending the puts them ry night. Ety policy at extending the puts them ry night.		TAG	DEFICIENCY)		DATE
	4. Through the goals of re are reinforced	the resident care plan, habilitative nursing care					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/27/2012
NAME OF F	ROVIDER OR SUPPLIER	8140 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	3.1-35(b)(1)			

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Event ID: S5QT11

Facility ID: 000105

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155198	B. WING		02/27/2012
MARQUE	PROVIDER OR SUPPLIE	R	8140	FADDRESS, CITY, STATE, ZIP CODE TOWNSHIP LINE RD NAPOLIS, IN 46260	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0318 SS=D	RANGE OF MC Based on the co a resident, the f resident with a l receives approp to increase rang further decrease Based on obse and interview, ensure a rehal exercise progr 1 of 3 resident (range of motio criteria for RO #104) Findings include Resident #104 on 2/23/12 at 9 Current diagnor not limited to, carcinoma - m dementia - Alz constipation, a hepatic encept Disease, and of During the star at 10:00 A.M., Resident #104	omprehensive assessment of acility must ensure that a imited range of motion oriate treatment and services ge of motion and/or to prevent e in range of motion. ervation, record review, the facility failed to collitative or restorative am was established for s reviewed for ROM con) of 4 who met the M services (Resident de: "S record was reviewed 9:40 A.M. oses included, but were	F0318	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: As documented in this survey, Resident #104 demonstrated ability "to fully open her hands and fingers". She was screen on 2/28/12 by hospice occupational therapy, which provided this assessment: "During the evaluation, the resident actively opened hand with verbal cues. Therapist we able to gently range digits. The was no increased tone observed." The therapist recommended bilateral soft particular protectors and alternate uses spatient is able to use right hand functionally for ADLs. Soft parentectors were ordered, per hospice. How other residents having the potential to be affected by the same deficient practice we identified and what corrective action(s) will be taken: All residents have the potential be affected by the alleged deficient practice. All residents	the ed sas as arere alm o d lm

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155198	B. WIN			02/27/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OWNSHIP LINE RD		
MARQUE	TTE				IAPOLIS, IN 46260		
·			_		74 0210, 114 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG		DATE	
					were assessed by restorative		
	The current car	e plans available in			nursing staff to ensure that all residents with a limited range	of	
	the record were	e all originated on			motion receive appropriate	JI .	
	8/4/11. The ca	re plans were printed			treatment and services to		
	on 1/26/12, wh	ich was the last care			increase range of motion and/o	or	
	· ·	e also. The current			to prevent further decrease in		
	care plans did				range of motion.		
		splint or Range of			What measures will be put in	nto	
		•			place or what systemic		
		storative program.			changes will be made to		
					ensure that the deficient		
		view with the Second			practice does not recur:		
	Floor Unit Man	ager (UM) on 2/23/12			All nursing staff will be		
	at 10:45 A.M.,	she indicated the			re-educated regarding the Rehabilitative Nursing Care Po	alicy	
	resident did ha	ve contractures of both			and Procedure, including the	лісу	
	hands.				importance of reporting and/ o	r	
					referring those residents		
	During observa	tion of Resident #104			demonstrating any decline or		
		0:50 A.M., Resident			change in functional capacity.		
		•			Residents identified with		
		ucted by the UM to			significant changes will be		
	•	s and fingers, which			discussed in morning	- 1-	
		d position. The			interdisciplinary team meetings ensure interventions are in pla		
		ole to fully open her			and care plans are modified	Ce	
	hands and fing	ers, but needed some			appropriately.		
	assistance of h	er right hand to open			How the corrective action(s)		
	the left hand.	The UM indicated the			will be monitored to ensure t	he	
	resident had ar	thritis in her hands,			deficient practice will not rec	ur,	
	causing the enl	arged knuckles, stiff			i.e., what quality assurance		
	joints and crool				program will be put into place	e:	
	,5				All residents will be assessed		
	At this time the	e UM indicated the			range of motion upon admission	· · · · · · · · · · · · · · · · · · ·	
					quarterly, and with any signific	ant	
		be evaluated for			change of condition. Nursing	lite	
	·	possible splinting to			administration will conduct aud to ensure appropriate reporting		
	·	ctures and the risk for			and referral for treatment has		
	contractures sh	ould be addressed on			been completed for those		
	the resident's c	are plan.			residents in their assessment		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ΓED
		155198	B. WIN			02/27/2	012
			р. W II V	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OWNSHIP LINE RD		
MARQUE	ETTE				APOLIS, IN 46260		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A current facilit and last review "Rehabilitative provided by the Nursing) on 2/2 indicated: " Policy State provide nursing meet ADL (Actineeds for those carry out these decline in posit or (3) maintain ADLs or ROM a Procedure: Genursing care is require the use Professional Trace. 1. The goal of rehabilitative nuto assist each maintain an operand independe activities of dail 3. Rehabilitative performed as mesidents who in Such care incluto: f. Assisting moutine range of	y policy, dated 4/07 ed 2/12, titled Nursing Care", e DON (Director of 27/12 at 8:30 A.M., ement: The facility will g care in order to (1) evities of Daily Living) e residents unable to activities; (2) prevent ioning, ADLs or ROM; or improve positioning, abilities eneral rehabilitative that which does not of a Qualified herapist to render such the facility's cursing care is designed resident to achieve and timal level of self-care nce through normal			review period. Any residents exhibiting a decline in function capacity will be referred to therapy for screening. Information gathered from the audits will be forwarded to the committee quarterly. See Attachment B, Comprehensive Assessment Audit Form.	QA	
	4. Through 1	the resident care plan,				1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	155198	A. BUILDING	ì		02/27/	
			B. WING	EET A	DDRESS, CITY, STATE, ZIP CODE	-	-
NAME OF P	PROVIDER OR SUPPLIER	R			OWNSHIP LINE RD		
MARQUE	ETTE				APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ACH CORRECTIVE ACTION SHOULD BE	
IAG		LSC IDENTIFYING INFORMATION)	TAC	J	DEFICIENC!)		DATE
	the goals of rehabilitative nursing care are reinforced in the						
		ram, Therapy Services,					
	etc."						
	3.1-42(a)(2)						

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Event ID: S5QT11

Facility ID: 000105

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			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155198	B. WIN			02/27/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OWNSHIP LINE RD		
MARQUE	TTE				APOLIS, IN 46260		
W/ (TQOL				II VIDI/ (IV.	711 OLIO, 11 1 40200		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0334	483.25(n)						
SS=E		D PNEUMOCOCCAL					
	IMMUNIZATION						
		develop policies and					
	procedures that						
		g the influenza immunization,					
		the resident's legal eceives education regarding					
		potential side effects of the					
	immunization;	poternial side effects of the					
	•	t is offered an influenza					
		tober 1 through March 31					
		the immunization is					
	•	indicated or the resident has					
	already been imr	munized during this time					
	period;						
		or the resident's legal					
	-	as the opportunity to refuse					
	immunization; ar						
		's medical record includes					
		nat indicates, at a minimum,					
	the following:	sident or resident's legal					
		as provided education					
	•	nefits and potential side					
		za immunization; and					
		sident either received the					
	, ,	ization or did not receive the					
		ization due to medical					
	contraindications	s or refusal.					
	-	develop policies and					
	procedures that						
	` '	g the pneumococcal					
		ach resident, or the resident's					
		tive receives education					
		nefits and potential side					
	effects of the imr	nunization; t is offered a pneumococcal					
		nless the immunization is					
		indicated or the resident has					
	already been imr						
	andady boom in						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155198	B. WING		02/27/2012
NAME OF F	PROVIDER OR SUPPLIER		8140 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	representative himmunization; ar (iv) The resident documentation the following: (A) That the resident documentation the following: (A) That the resident documentation the following: (B) That the resident documentative with the feets of pneumococcal in receive the pneumococcal in	Is medical record includes that indicated, at a minimum, sident or resident's legal as provided education nefits and potential side tococcal immunization; and sident either received the inmunization or did not imococcal immunization due aindication or refusal. Itive, based on an practitioner as second pneumococcal as be given after 5 years at pneumococcal inless medically or the resident or the epresentative refuses the action. The dreview and accility failed to ensure education were assidents receiving the ine for 5 of 5 residents fluenza vaccines in a second 29 (Resident # 1, # 43 and # 118).	F0334	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility's policy and proces for the Immunization Program has been revised to include annual education and consent the resident or responsible paraprior to administering the influenza vaccine. In the future resident #'s 102, 104, 81, 43, 118 will receive education and sign a new consent each year prior to receiving the influenza vaccine. How other residents having the potential to be affected by the	dure t of rty ee, and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00		COMPLETED
		155198	A. BUILDING			02/27/2012
		1	B. WING		WALL OF A THE CORE	
NAME OF I	PROVIDER OR SUPPLIE	R			TTY, STATE, ZIP CODE	
				0 TOWNSHIP		
MARQUE	EIIE		INL	IANAPOLIS, I	N 46260	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PRO	OVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFI			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAC		DEFICIENCY)	DATE
	flu vaccine in t	he fall of 2011:		same de	eficient practice will	be
				identifie	d and what corrective	ve e
	The record for	Resident # 102 was		action(s) will be taken:	
		23/12 at 2:30 P.M.			ents have the potentia	al to
					ted by the alleged	
		nt documented for			practice. The facility	's
	Resident # 102	2 was 10/28/10.			nd procedure for the	
					ation Program has be to include annual	een
	The record for	Resident # 104 was			n and consent of the	
	reviewed on 2/	23/12 at 9:40 A.M.		l l	or responsible party	
	The last conse	nt documented for			istering the influenza	-
	Resident # 104	1 was 9/23/10.		vaccine.	Ü	
				What me	easures will be put i	nto
	The record for	Resident # 81 was		place or	what systemic	
		21/12 at 1:00 P.M.		changes	will be made to	
				ensure t	hat the deficient	
		nt documented for		1 '	does not recur:	
	Resident # 81	was 10/3/07.			sed nurses will be	
					d regarding the revise	
	The record for	Resident # 43 was			ation Program. Prior	to
	reviewed on 2/	21/12 at 2:00 P.M.			ration,the facility will the resident or	
	The last conse	nt documented for		l l	ble party to the risk a	and
	Resident # 43	was 10/10/10.			of the influenza vacc	
					in a signed consent t	
	The record for	Resident # 118 was			ine to be administere	
				This sign	ned consent will	
		21/12 at 1:30 P.M.		be place	d in the resident's	
		nt documented for		medical		
	Resident # 118	3 was 5/20/10.		l l	e corrective action(s	· I
					nonitored to ensure	****
	Consent and e	ducation			t practice will not re	cur,
	documentation	was requested for the			t quality assurance	
	influenza vacc	ines on 2/24/12 at			n will be put into place administration will	ce.
	11:00 A.M.				an audit prior to the	
					offluenza vaccination	
	During an inter	view on 2/24/12 at			to assure that conser	nts
					en received. The nur	
		the Director of Nursing,			ents vaccinated and th	
	she indicated t	here was no further				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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WING	COMPLETED 02/27/2012
STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260	
PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION DATE
number of declinations will reviewedbythe QACommi	l be ttee.
	WING STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 ID PREFIX CEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPREDEFICIENCY) number of declinations will reviewedbythe QACommit See Attachment D, Influer

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/27/2012
NAME OF P	PROVIDER OR SUPPLIE	R	8140 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	& BIOLOGICAL The facility musservices of a lice establishes a sy and disposition sufficient detail reconciliation; a records are in ocontrolled drugs periodically records and biologically records and biologically records are in ocontrolled drugs periodically records and biologically records and biologically records and accepted profess the appropriate instructions, and applicable. In accordance with facility must biologicals in log proper tempera authorized persisters. The facility must permanently aff storage of control of the Compressive prevention and drugs subject to facility uses sing distribution systimatics.	DS, LABEL/STORE DRUGS S It employ or obtain the ensed pharmacist who stem of records of receipt of all controlled drugs in to enable an accurate and determines that drug reder and that an account of all is is maintained and onciled. Igicals used in the facility must cordance with currently issional principles, and include accessory and cautionary in the expiration date when with State and Federal laws, store all drugs and cked compartments under ture controls, and permit only onnel to have access to the it provide separately locked, fixed compartments for olled drugs listed in Schedule enensive Drug Abuse Control Act of 1976 and other in abuse, except when the gle unit package drug ems in which the quantity all and a missing dose can be			
	and interview, ensure a resid	ervation, record review the facility failed to ent's medications were or 1 of 8 medication	F0431	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	

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Event ID: S5QT11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLE	ETED
		155198	B. WIN			02/27/2	2012
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			OWNSHIP LINE RD		
MARQUI	ETTE				IAPOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cart observation	ns (Resident # 186			While the nurse involved in the	•	
	and LPN #1).				alleged incident did not follow		
					best practices, the cart was		
	Findings include:				always within line of site. The nurse observed the surveyor		
					approach the cart and therefor	-e	
	During chaony	ation of the modication			the resident's medication was	Ĭ	
	_	ation of the medication			never truly at risk. The		
		floor Rehabilitation			medications for resident #186		
		2 at 9:40 A.M., the cart			were immediately secured by	the	
		d and the Medication			nurse involved in the alleged		
	Administration	Record (MAR) was			incident.		
	open to Resident # 186's medications, and medications were pre-set in a medication cup.				How other residents having t		
					potential to be affected by th		
					same deficient practice will be identified and what corrective		
	'	·			action(s) will be taken:	e	
	During an inter	view with LPN # 1 on			All residents have the potentia	l to	
		5 A.M., she indicated			be affected by the alleged		
					deficient practice. All licensed		
		nsible for the rehab			nurses and qualified medication		
		t. She also indicated			aides (QMAs) will be re-educa	ted	
		e medications should			regarding the guidelines for		
		left on top of the			medication administration and	the	
	medication car	t unattended.			facility policy.	.	
					What measures will be put in	ito	
	A current facilit	ty policy dated 1/1/05			place or what systemic changes will be made to		
	and titled "Gen	eral Guidelines for			ensure that the deficient		
	Administering	Medication" and			practice does not recur:		
	_	e Director of Nursing on			The nurse involved in the alleg	_{led}	
		30 P.M. indicated,			incident has been reprimanded		
		Guidelines for			accordance with facility policy		
					re-educated regarding the		
	handling medic				guidelines for medication		
		ons are administered at			administration and the facility	_	
	•	re prepared. They are			policy. All licensed nurses and	u	
	not pre-poured	or pre-set in any			qualified medication aides (QMAs) will be re-educated		
	manner.				regarding the guidelines for		
	6 No me	dication is kept on top			medication administration and	the	
	of the cart or a	ccessible to other			facility policy. Continuing	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 02/27/2012		
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	residents when unattended." 3.1-25(m)			education will occur with newlinited nurses and qualified medication aides (QMAs) and annually thereafter for all nurse and qualified medication aides (QMAs). How the corrective action(swill be monitored to ensure deficient practice will not recise, what quality assurance program will be put into place Nursing administration will complete random audits daily through March 31, 2012, randomly three times a week through April 30, 2012, and the weekly through May 31, 2012 Information gathered from the audits will be forwarded to the committee quarterly. See Attachment A, Medication Administration Audit Form.	y ess cour, ese:		

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		155198	B. WING		02/27/2012
			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER			8140	TOWNSHIP LINE RD	
MARQUETTE			INDIA	ANAPOLIS, IN 46260	
(X4) ID	CHMMADV C	TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
		LESC IDENTIFY ING INFORMATION)	IAG		DATE
F0441 SS=D	483.65	NTROL, PREVENT			
33-0	SPREAD, LINE				
		establish and maintain an			
		Program designed to			
		sanitary and comfortable			
		to help prevent the			
	development and	d transmission of disease			
	and infection.				
	(a) Infection Cor				
	•	establish an Infection			
	Control Program	controls, and prevents			
	infections in the				
		t procedures, such as			
		be applied to an individual			
	resident; and	The state of the s			
		ecord of incidents and			
	corrective action	s related to infections.			
	#\\ D				
		pread of Infection			
	· ·	ection Control Program a resident needs isolation to			
		ad of infection, the facility			
	must isolate the	-			
		nust prohibit employees with a			
	• •	lisease or infected skin			
	lesions from dire	ect contact with residents or			
	their food, if dire	ct contact will transmit the			
	disease.				
	• •	nust require staff to wash their			
		direct resident contact for			
		hing is indicated by accepted			
	professional pra	cuce.			
	(c) Linens				
		handle, store, process and			
		so as to prevent the spread			
	of infection.				
	Based on obse	ervation, interview and	F0441	What corrective action(s) w	iII 03/28/2012
		the facility failed to		be accomplished for those	

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Facility ID: 000105

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		STRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155198	A. BUILDING B. WING			02/27/20	
		1	_	REET AD	DRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			WNSHIP LINE RD		
MARQUE	TTE				POLIS, IN 46260		
					OLIO, IIV 40200		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREF	ı	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA		·		DATE
		ent with physician's			residents found to have beer	ו	
		act isolation for			affected by the deficient		
	Methicillin-resis	stant Staphylococcus			oractice: Jpon admission, a precaution:	arv	
	Aureus (MRSA	in the nares			sign had been placed at the do		
	remained in co	ntact isolation until the			of Resident #182. Staff were	.	
	order was disc	ontinued, for 1 of 1			ollowing standard precautions	s in	
		ved for contact isolation		t	he provision of his care. The		
		ample of 29 (Resident			acility policy entitled "Infection		
	# 182).	ample of 20 (Rooldon)			Control Guidelines for the Use	of	
	$\frac{\pi}{102}$				Precaution Signs" states that		
	Findings includ	la.			contact precautions require signage when there is a likelih	004	
	Findings includ	ie.			of visitors and/or staff coming		
					contact with blood or body fluid		
The record for Resident # 182 was				which are not contained.			
	reviewed on 2/	23/12 at 2:50 P.M.			Resident #182 was exhibiting	no	
					nasal drainage and nursing		
	Diagnoses for	Resident # 182			administration was in process		
	included but we	ere not limited to			consulting the attending physic	cian	
	MRSA, End St	age Renal Disease and			regarding the actual need for solation.		
	Diabetes.	-			Solation. Resident #182 no longer resid	_ S	
					at the facility. It was determine		
	The resident w	as admitted on			by the attending physician pric		
	2/17/12.	as admitted on		ŀ	nis discharge that this resident		
					did not require contact		
	A current phys	ician's admission order			precautions and the precaution	ns	
	A current physician's admission order				were discontinued.	ا	
		indicated a need for			How other residents having to potential to be affected by th		
		on and Vancomycin 500		1 -	same deficient practice will b		
	•	avenous at 60 milliliters			dentified and what corrective		
	per hour.				action(s) will be taken:	·	
	A discharge note from the hospital on				All residents have the potentia	l to	
					be affected by the alleged		
2/17/12 indicated the resident required contact isolation due to		ed the resident			deficient practice. A review of		
		ct isolation due to			medical records was complete		
	MRSA.				Appropriate signage is in place	e	
					per policy for all residents	tion	
	During an inter	view with the resident			dentified with applicable infect What measures will be put in		
1	ו שטוווואַ מוו ווונכו	VICAN MAIRI RIIC LEGIUETIK	1	, ,	rvnat nicasuies Will De Dul III	LU I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITT	LDDIC	00	COMPLI	ETED	
155198			LDING		02/27/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R					
					OWNSHIP LINE RD		
MARQUE	EIIE			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 2/20/12 at 1	10:45 A.M., he			place or what systemic		
	indicated he di	id not attend activities			changes will be made to		
		d not want to and he			ensure that the deficient		
		n so he preferred to			practice does not recur:		
		•			All nursing staff will be		
	1	m. Also during the			re-educated to the facility's po		
		nknown visitor entered			on "Infection Control Guideline		
		room and asked to			for the Use of Precaution Sign	s".	
	speak to the re	esident at another time.			Licensed nurses and qualified medication aides (QMAs) will l	he	
	While in the ro	om the unknown visitor			responsible to check for	U C	
	leaned against	t the end of the bed			appropriate precautionary		
		I on the bed and then			signage every shift and docum	nent	
		s or gown was worn and			on the applicable residents'		
		_			treatment record.		
		ing was observed. The			How the corrective action(s)		
		was also in the room			will be monitored to ensure t	he	
	without any pro	otection on.			deficient practice will not rec	ur,	
					i.e., what quality assurance		
	Upon exiting the	ne resident's room no			program will be put into plac	e:	
	sign was obse	rved alerting staff or			Nursing Administration will		
	visitors to see	the nurse prior to			complete audits daily through		
	entering the re	•			March 31, 2012, three times a		
		isiaeme reem.			week through April 30, 2012, a then weekly through May 31,	and	
	Dumina an inta	- i - · · · · i do DN # 2			2012. Information gathered from	om	
	_	rview with LPN # 3 on			the audits will be forwarded to		
		00 A.M., she indicated			QA Committee quarterly. See		
	she did not kno	ow if the resident was			Attachment C, Precautionary		
	on isolation pro	ecautions and would			Audit Form.		
	have to check	his chart. After LPN #					
	3 reviewed his	record, she indicated					
		d have orders for					
		utions and there should					
	•	is door alerting visitors					
		•					
		se before entering the					
	room.						
	During an inter	rview with the Director					
	of Nursing (DC	ON) on 2/23/12 at 1:00					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
155198		B. WING		02/27/2012		
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIEI	K		OWNSHIP LINE RD		
MARQUE			INDIAN	NAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		ated if they admit a				
		as MRSA, they follow				
		utions and either put				
		by themselves or they				
		ith another resident				
		hey also post a sign on				
		taff lets management				
	know if other v	isitors or staff are not				
	complying with	the precautions.				
	During an inter	view with the DON and				
	Rehab Unit Ma	anager on 2/23/12 at				
	3:15 P.M., the	Unit Manager indicated				
		ed isolation precautions				
		end and the resident				
		the isolation room. She				
	<u>-</u>	at that time, they don't				
		sign unless staff and				
		come in contact with				
	blood or body					
		was requested				
		•				
	verifying the resident was not in need of contact isolation when he was					
	admitted to the	: lacility.				
	As of the time	of exit on 2/27/12 at				
		further documentation				
	was provided.					
	mao provided.					
	A current undated facility policy titled "Infection Control Guidelines for Use of Precaution Signs" and provided by					
the Rehabilitation Unit Manager		•				
		5 P.M. indicated,				
	"Policy: Preca	ution signs are used to				

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Event ID: S5QT11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155198	A. BUILDING B. WING	00	COMPLETED 02/27/2012			
NAME OF I	PROVIDER OR SUPPLIER	8140 T	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	alert staff and visitors to conditions requiring special infection control practices, above and beyond Universal or Standard Precautions Standards: 3.c. Contact Precautions require signage when there is a likelihood of visitors and/or staff entering the room coming into contact with blood or body fluids which are not contained by a wound dressing or closed catheter system." 3.1-18(b)						

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Event ID: S5QT11

Facility ID: 000105

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